NEW HAMPSHIRE RETIREMENT SYSTEM
4 CHENELL DRIVE
CONCORD, NH 03301-8509
(603) 271-3351

FOR NHRS USE ONLY
*EMPR#*_____
*VENDOR#*_____
SUB ELIGIBLE Y____ N____
DATE PROCESSED _____
INITIALS _____

DedauthM 6/05

RETIREMENT ANNUITY DEDUCTION AUTHORIZATION FOR RETIRED MARRIED MEMBERS ONLY

Retiree Name _____ Social Security # _____ DOB _____
Spouses Name _____ Social Security # _____ DOB _____
Address _____
_____ Telephone # _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Effective Date of Request: _____ **Requested Action:**

Member Premium, Health	$_____	_____
Spouse Premium, Health	$_____	_____
Expected Subsidy, if applicable	$_____	_____
Dental Plan (where available)	$_____	_____
Total Monthly Rate	$_____	_____
Expected Deduction	$_____	_____

Employer (City, Town, County, School):

Name_____ Group #_____
Address_____ Provider Name: _____
Telephone #_____ Contact Name _____

Please read and initial one:

_____ **Group I-Employee and Teacher**: I understand that the amount of the deduction hereby authorized to be made from my monthly retirement benefit payment shall be the *Total Monthly Rate* shown above. This amount may increase or decrease without further notice to me as costs of my coverage changes and I hereby authorize said additional amounts to be deducted.

_____ **Group II-Police and Fire**: I understand that the amount of the deduction hereby authorized to be made from my monthly retirement benefit payment shall be the *Total Monthly Rate* shown above. This amount may increase or decrease without further notice to me as costs of my coverage changes and I hereby authorize said additional amounts to be deducted.

If it is determined by the NHRS that I qualify for a health insurance subsidy benefit pursuant to RSA 100-A:50-55, ***and should have a certifiably dependent child with a disability who is also eligible***, said subsidy amount will be applied to my health insurance premium. ***Any*** remaining amount will be deducted from my monthly retirement benefit payment effective the first of the month following attainment of eligibility.

Change in Membership Status: If I become divorced, ***my spouse or certifiably dependent child becomes deceased, or should I, my spouse or certifiably dependent child with a disability become Medicare eligible***, I understand that I must notify my former employer of the change in my eligibility status for the medical subsidy. ***I*** understand that the New Hampshire Retirement System reserves the right to recover any subsidy amounts paid on behalf of a divorced or deceased spouse, deceased spouse or certifiably dependent child, or ***any overpayment of subsidy due to the lack of Medicare information***.

Member/Policy Holder Signature_____ Date_____

Spouse Signature_____ Date_____